PART XI: CHILD DEATHS

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The review of child deaths reported to CPS can best be achieved through a multi-agency, multi-disciplinary process that routinely and systematically examines circumstances surrounding reported deaths of children ages 0 to 18. The purpose of the review is to enable the Virginia Department of Social Services, the local departments of social services, and local community agencies to identify important issues related to child protection and to take appropriate action to improve our collective efforts to prevent child fatalities. The review process at all levels emphasizes that DSS is not alone in its responsibility to protect children, and reports should address issues of interagency collaboration, communication and decision-making.

When a CPS report involves a child death, the local department must meet ALL investigation requirements according to the CPS Guidance Manual. Refer to Part III: Complaints and Reports and Part IV: Family Assessment and Investigation.

A. Report A Child Death

The Virginia Administrative Code requires local departments to contact the Medical Examiner, Commonwealth's Attorney and local law enforcement when a report or complaint alleging abuse or neglect involves the death of a child.

1.0 Report Child Death to Regional Medical Examiner

Va. Code § 63.2-1503(E) and 22VAC40-705-50(F) (1). When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall pursuant to § 63.2-1503(E) of the Code of Virginia.

The local department must immediately notify the regional medical examiner when the local department receives a complaint or report of abuse or neglect involving the death of a child. The local department should advise the medical examiner if the local department will be proceeding with an investigation.

2.0 Report Child Death to Local Commonwealth's Attorney and Law-Enforcement

22VAC40-705-50(F) (2). When abuse and/or neglect is suspected in any case involving the death of a child, the local department shall report the case immediately to the attorney for the Commonwealth and the local law-enforcement agency pursuant to § 63.2-1503 (D) of the Code of Virginia.

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The local department must immediately notify the local Commonwealth's Attorney and local law-enforcement when the local department receives a complaint or report of abuse or neglect involving the death of a child. The local department should advise the Commonwealth's Attorney and local law-enforcement if the local department will be proceeding with an investigation.

B. Submit Preliminary Child Death Information To CPS Regional Specialist

22VAC40-705-50(F) (3). The local department shall contact the Department immediately upon receiving a complaint involving the death of a child and at the conclusion of the investigation.

The local department's CPS supervisor or supervisor's designee shall contact the child protective services regional specialist immediately upon receiving a complaint involving the death of a child.

The CPS regional specialist shall complete Part I: Child Fatality Information Form and forward it to the CPS Program Manager within 24 hours of receipt of the information pertaining to the death of the child.

The CPS Program Manager shall inform the Commissioner's Office of the child death within 24 hours. This information is also shared with the State Board of Social Services.

1.0 Submit Preliminary Information Concerning the Child Death

The local department shall provide the following preliminary information concerning the child death to the CPS Regional Specialist who will submit the information on the Child Fatality Information Form to the CPS Program Manager.

Part I of the Child Fatality Information Form provides initial or preliminary information about the child death and shall be completed with as much of the following information as possible.

1.1 Logistical Information

1. Name of Local Department
2. Name of Investigating Worker
3. Name of CPS Supervisor
4. Date of Complaint
5. Referral Number
6. Person Making the Complaint
7. Regional Specialist

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1.2. Demographic Information

1. Name of Deceased Child
2. Deceased Child's Date of Birth
3. Date of Child's Death
4. Sex of Child
5. Race of Child
6. Type of Alleged Abuse/Neglect
7. Name of Alleged Abuser/Neglector
8. Relationship of Alleged Abuser/Neglector to Child

1.3. Reporting Requirements

1. Date Reported to CPS Regional Specialist
2. Date Reported to Commonwealth's Attorney
3. Date Reported to Law Enforcement
4. Date Reported to Regional Medical Examiner
5. Date Reported to CPS Program Manager

1.4. Circumstances Surrounding the Child's Death

1. Detailed Description of the Child's Death (When, where, why, how, who, and any related problems, including type of abuse/neglect)
2. Information Concerning the Family's Prior Involvement with the Local Department (Include a summary of prior reports and referral numbers)
3. Information Concerning the Alleged Perpetrator of the Child's Death (Relationship to victim or other family members)
4. Identification (Including Names and Ages) of any Siblings of the Deceased Child – (Requires conducting a safety assessment of any siblings of the deceased child and development of a Safety Plan, if safety decision is Conditionally Safe or Unsafe.)

1.5. Local Department's Plan of Action

1. Description of the Local Department's Investigation Plan
2. Description of the Regional Specialist's Planned Involvement and Assistance
3. Date Disposition is Due
4. Any Additional Concerns or Comments

C. CPS Regional Specialist To Monitor Investigation And Provide Technical Assistance To Local Department

The CPS regional specialist shall provide technical assistance to the local department throughout the investigation. *The local department shall consult with*

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the CPS regional specialist prior to making the disposition and developing the service plan.

The local department is encouraged to utilize interdisciplinary teams to staff fatality cases to enhance the process for shared decision making.

The CPS regional specialist shall provide regular status reports to the CPS program manager on all investigations involving a child death.

1.0 Final Child Death Report and Review

Within 10 working days of the disposition or as soon as possible thereafter, the CPS regional specialist shall complete the Child Fatality Information Form in conjunction with the local department *and submit Part I and Part II of the Child Fatality Information Form concerning the child death to the CPS Program Manager*. The review may be conducted by a local or regional child fatality review team and must address all elements of the Child Fatality Information Form. A copy of the form is in the Appendix.

1.1 Child Fatality Information Form

Part I: Complete or update preliminary information submitted at the beginning of the investigation

Part II:Complete the following information at the conclusion of the investigation.

1. *Disposition of the Investigation*
2. *Risk Assessment for other Children in the Home*
3. *Summary of Criminal Charges (if any)*
4. *Child Characteristics (include any physical or mental disabilities)*
5. *History of the Family & Caretaker (include marital status, physical or mental disabilities, drug/substance abuse or domestic violence involvement)*
6. *Economic or Environmental Factors (indicate if the family is receiving public assistance, serving in the military, and if relevant, risk factors present in the home or neighborhood.)*
7. *Service Plan, including assessment of Interventions with the Family*
8. *Assessment of Local and/or Systemic Issues that May Have Impacted the Child's Death*
9. *Recommendations to Improve Community Response, Enhance Services and Prevent Child Deaths*

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D. Local, Regional And State Child Fatality Reviews

The *Code of Virginia* authorizes reviews *of c*hild deaths at the local, regional and/or state level. Localities are encouraged to utilize local or regional teams to examine the circumstances of a death and answer questions about why the death occurred and whether it might have been prevented.

1.0 Local and Regional Child Death Review Teams

§ 32.1-283.2 Local and regional child fatality review teams established; membership; authority; confidentiality; immunity.

A. Upon the initiative of any local or regional law-enforcement agency, fire department, department of social services, emergency medical services agency, Commonwealth's attorney's office, or community services board, local or regional child fatality teams may be established for the purpose of conducting contemporaneous reviews of local child deaths in order to develop interventions and strategies for prevention specific to the locality or region. Each team shall establish rules and procedures to govern the review process. Agencies may share information but shall be bound by confidentiality and execute a sworn statement to honor the confidentiality of the information they share. Violations shall be punishable as a Class 3 misdemeanor. The State Child Fatality Review Team shall provide technical assistance and direction as provided for in subsection A of § 32.1-283.1.

B. Local and regional teams may be composed of the following persons from the localities represented on a particular board or their designees: a local or regional medical examiner, a local social services official in charge of child protective services, a director of the relevant local or district health department, a chief law-enforcement officer, a local fire marshal, the attorney for the Commonwealth, an executive director of the local community services board or other local mental health agency, and such additional persons, not to exceed five, as may be appointed to serve by the chairperson of the local or regional team. The chairperson shall be elected from among the designated membership. The additional members appointed by the chairperson may include, but are not restricted to, representatives of local human services agencies; local public education agencies; local pediatricians, psychiatrists and psychologists; and local child advocacy organizations. confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5.

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§ 32.1-283.2 Local and regional child fatality review teams established; membership; authority; confidentiality; immunity. (continued)

C. Each team shall establish local rules and procedures to govern the review process prior to conducting the first child fatality review. The review of a death shall be delayed until any criminal investigations connected with the death are completed or the Commonwealth consents to the commencement of such review prior to the completion of the criminal investigation.

D. All information and records obtained or created regarding the review of a fatality shall be confidential and shall be excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 9 of § 2.2-3705.5. All such information and records shall be used by the team only in the exercise of its proper purpose and function and shall not be disclosed. Such information or records shall not be subject to subpoena, subpoena duces tecum, or discovery or be admissible in any criminal or civil proceeding. If available from other sources, however, such information and records shall not be immune from subpoena, subpoena duces tecum, discovery or introduction into evidence when obtained through such other sources solely because the information and records were presented to the team during a fatality review. No person who participated in the reviews nor any member of the team shall be required to make any statement as to what transpired during the review or what information was collected during the review. Upon the conclusion of the fatality review, all information and records concerning the victim and the family shall be returned to the originating agency or destroyed. However, the findings of the team may be disclosed or published in statistical or other form which shall not identify individuals. The portions of meetings in which individual cases are discussed by the team shall be closed pursuant to subdivision A 21 of § 2.2-3711. All team members, persons attending closed team meetings, and persons presenting information and records on specific fatalities to the team during closed meetings shall execute a sworn statement to honor the confidentiality of the information, records, discussions, and opinions disclosed during any closed meeting to review a specific death. Violations of this subsection shall be punishable as a Class 3 misdemeanor.

E. Members of teams, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a child fatality review team review, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports or records to review teams as part of such review, shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

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2.0 State Child Fatality Review Team

The *Code of Virginia established a* statewide team to analyze child deaths in a systematic way. This includes child deaths due to abuse or neglect as well as child deaths due to other causes.

§ 32.1-283.1 State Child Fatality Review Team established; membership; access to and maintenance of records; confidentiality; etc.

A. There is hereby created the State Child Fatality Review Team, hereinafter referred to as the "Team," which shall develop and implement procedures to ensure that child deaths occurring in Virginia are analyzed in a systematic way. The Team shall review (i) violent and unnatural child deaths, (ii) sudden child deaths occurring within the first 18 months of life, and (iii) those fatalities for which the cause or manner of death was not determined with reasonable medical certainty. No child death review shall be initiated by the Team until conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for the review of child deaths, including identification of cases to be reviewed and procedures for coordination among the agencies and professionals involved, (ii) improve the identification, data collection, and record keeping of the causes of child death, (iii) recommend components for prevention and education programs, (iv) recommend training to improve the investigation of child deaths, and (v) provide technical assistance, upon request, to any local child fatality teams that may be established. The operating procedures for the review of child deaths shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision 17 of subsection B of § 2.2-4002.

E. Release Of Child Death Information

There are specific requirements related to the release of information in child deaths. The general discussion of laws and regulations regarding confidentiality and disclosure of information are discussed in Part IX: Confidentiality of this manual. The Virginia Administrative Code requires the Department to develop guidelines allowing for public disclosure in instances of a child death.

> 22VAC40-705-160(A)(8) Pursuant to the Child Abuse Prevention and Treatment Act, as amended (42 USC § 5101 et seq.), the department shall develop guidelines to allow for public disclosure in instances of child fatality or near fatality.

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1.0 Guidelines for Release of Information in a Child Death

The Virginia Administrative Code establishes the information that can be released in child abuse or neglect cases with a child death.

22VAC40-910-100B. Releasing confidential social services information.

3. b. Child Protective Services Client Records and Information Disclosure:

(1) Child protective services client records can be released to persons having a legitimate interest pursuant to § 63.2-105 A of the Code of Virginia.

(2) The public has a legitimate interest to limited information about child abuse or neglect cases that resulted in a child fatality or near fatality. Pursuant to the Child Abuse and Prevention Treatment Act (CAPTA), as amended (P.L. 104-235 (42 USC §5106a)) states must have provisions that allow for public disclosure of the findings or information about the case of child abuse or neglect that has resulted in a child fatality or near fatality. Accordingly, agencies may release the following information to the public, providing that nothing disclosed would be likely to endanger the life, safety, or physical or emotional well-being of a child or the life or safety of any other person; or that may compromise the integrity of a Child Protective Services investigation, or a civil or criminal investigation, or judicial proceeding:

(a) The fact that a report has been made concerning the alleged victim child or other children living in the same household;

(b) Whether an investigation has been initiated;

(c) The result of the completed investigation;

(d) Whether previous reports have been made concerning the alleged victim child or other children living in the same household and the dates thereof, a summary of those previous reports, and the dates and outcome of any investigations or actions taken by the agency in response to those previous reports of child abuse or neglect;

(e) The agency's activities in handling the case.

F. Retention Of CPS Report Involving A Child Death

The *Code of Virginia* § 32.1-283.1(D) requires the records of all reports involving a child death to be retained until the State Child Fatality Review Team has had an opportunity to review them. The reports to be retained include screened out reports, founded and unfounded investigations. Local departments may contact

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the CPS regional specialist if there is any question about retention of a specific record.